the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

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ISOLATION - PAGE 32

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for the physician in general practice

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The Cover

● In "The Rime of the Ancient Mariner," Coleridge related the awesome effects of solitude upon a man rejected by companions and burdened with guilt, as symbolized by the albatross. The poem contains dramatic descriptions of many of the sensory and intellectual phenomena that have only recently been demonstrated in experiments on the effects of isolation. A discussion of these phenomena begins on page 32.

● Cover drawing by Joseph F. Schwarting

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THE EDITORS

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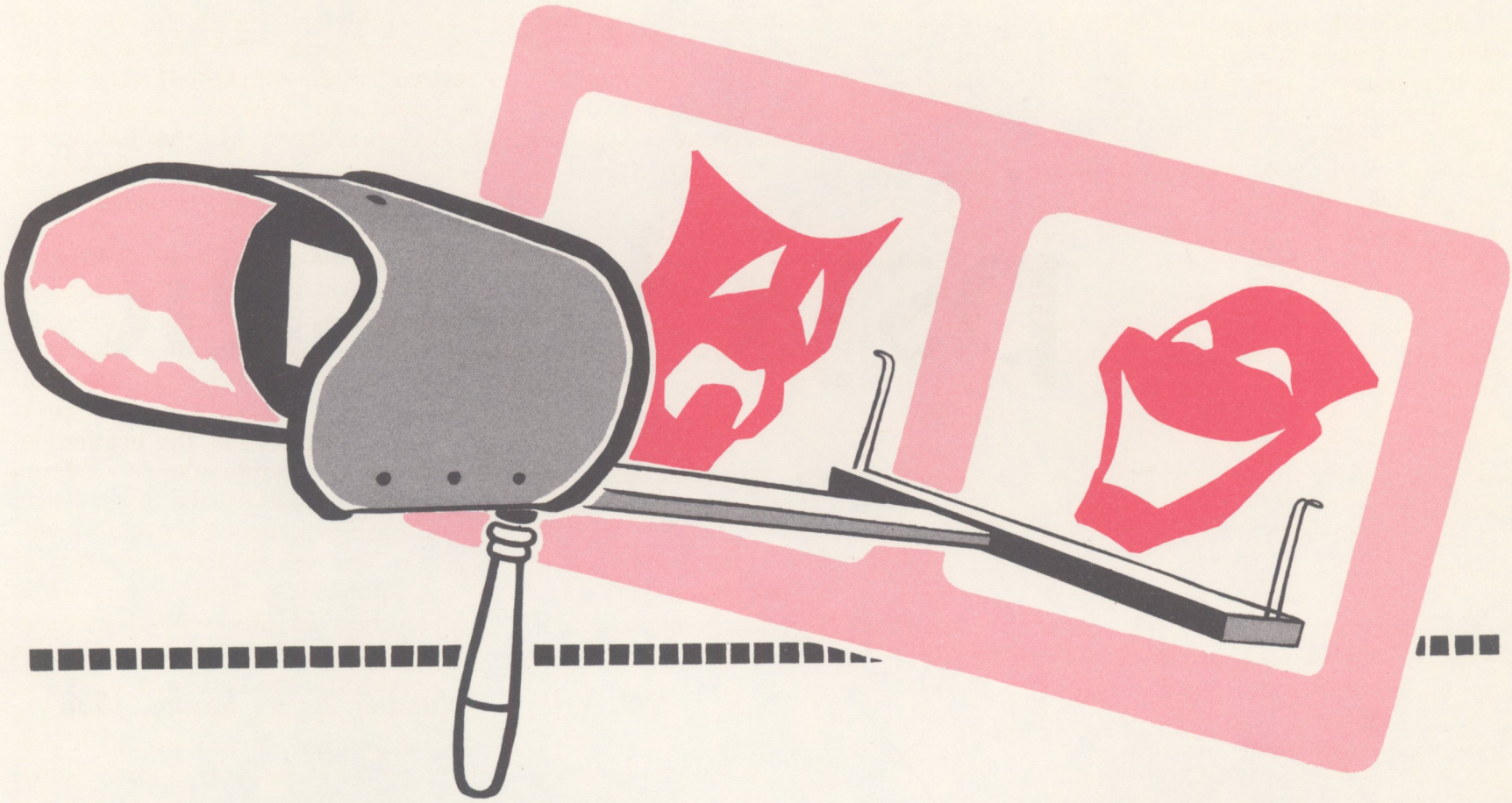

Manic-depressive Reaction

Psychodynamics, differential diagnosis, and prognosis

● ALTERNATE EPISODES of immoderate elation and severe depression characterize the *manic depressive reaction.* Either extreme of mood may vary in duration from less than a day to many years, and may recur after intervals of relative stability. Disorder that is characterized by elation or excitement, with logorrhea, rapid thought sequence, and hyperactivity is described as *manic depressive reaction, manic type.* In *manic depressive reaction, depressed type,* depression is characteristic, and psychomotor retardation and apprehension are sometimes discernible. A combination of some of the manifestations of both disturbances is referred to as *mixed type;* and continuous alternation between the two extreme moods is known as *circular type.*

The exact etiology of manic depressive reaction is not known. Kraepelin is credited with the initial description, in 1896, of the divergent nature of the disorder which he called *manic depressive psychosis.* Previously, investigators had recognized mania and depression as single entities but had not considered them as two components of one disease process.

Kretschmer, in 1921, described the *pyknic* type—the short, stocky, thickset body structure—as characteristic of manic depressive individuals. In a study that included 85 manic depressive patients, 58 were of the pyknic type and 14 were listed as pyknic mixture. At the same time, Kretschmer described the *cycloid* personality and designated it as the most frequent prepsychotic personality structure in manic depressive patients. According to Campbell, there are three categories of cycloid personality: the predominantly euphoric, the consistently pessimistic, and the *cyclothymic* in which the individual seems to oscillate between the two dispositions without apparent external cause. In general, the cycloid is an active, friendly, practical, extroverted person, in contrast to the schizoid, who is introspective, shy, and more interested in ideas than in other persons.

Progression of disorder

According to Alexander, the transition from cyclothymic personality to manic depressive reaction is a gradual one, and, in both the manic and the depressed phases, there are stages of progression. The disturbance may be arrested at any stage, or a stage may be passed without symptomatic evidence. Hoch has described the phases in this manner. The mildest form of mania (hypomania) is characterized by overactivity, exaggerated enthusiasm, jocosity, and quick thought association. The individual frequently plans and sometimes executes expansive programs in such pursuits as business enterprise, group organization, and charitable works. He is usually exceedingly affable during this stage, but also is intolerant of criticism, and may become irritable if his judgment is questioned. Hypomanic disorder may not be immediately apparent to the observer who has not known the patient previously.

The second stage, acute mania, results in intensification of the signs of hypomania. The patient develops psychomotor hyperactivity, elation, and rapid thought sequence or flight of ideas. The constant activity may be so great that food and sleep are often neglected. The patient may use profane and obscene language, and indulge in alcoholic and sexual excesses. Although intelligence, orientation, and memory remain essentially intact, restraint is absent, and the patient may act upon grandiose schemes, make unwise investments, and purchase useless, expensive objects. Despite the general elation, the patient may have momentary depression with crying, or may become combative, destructive, and easily enraged. He is easily distractible, however, and outbursts of antagonism can be diverted, but not prevented.

The third stage is that of delirious mania which is characterized by disorientation. Hallucinations and delusions are not uncommon, and the state is one of intense, sustained excitement, frenzied activity, and incoherence. Distractibility is such that neither sentences nor simple activities can be completed before the succeeding ones are started. This state may result in loss of environmental contact, physical exhaustion, and collapse, sometimes complicated by cardiac and respiratory difficulties.

The stages that precede the depressed phase of manic depressive reaction are, symptomatically, opposite to those in the manic phase. Mild depression is characterized by psychomotor inhibition, slowed thought processes, and depressive affect. Patients frequently complain of fatigue, sleeplessness, dyspepsia, and constipation. Self-blame, anxiety, feelings of inadequacy, and suicidal ideas may also be expressed. There is decreased interest in activities, and even the small undertakings of a daily routine may seem overwhelming.

In acute depression, the mood is one of hopelessness, dejection, and despondency. Psychomotor retardation is more pronounced, speech is limited, and negativism is evident. The patient may maintain a hypotonic position or move about in restless agitation. Concomitant disorders are anorexia, weight loss, early morning sleeplessness, cessation of menses, constipation, and decreased sexual inclination. Common hypochondriacal complaints may include such descriptions as wasting away of the brain, decay of segments of the body, or strange, incurable disease. Auditory and olfactory hallucinations occur, and feelings of unreality or unworthiness may be expressed, in addition to delusions of sin and of poverty. Most outstanding and, of course, most hazardous to the patient, are the ideas of self-depreciation, self-mutilation, and self-destruction. Suicide is a constant danger; acutely depressed patients will attempt and accomplish suicide if not prevented. According to Strecker and others, these patients deliberately seem to select especially painful methods of self-destruction.

Exacerbation of acute depression may culminate in depressive stupor. First, self-accusation is expanded to include blame for all the ills of the world, with punishment necessarily in proportion to responsibility. In the patient's tormented state of mind his thoughts are insupportable and he becomes mute, immobilized, and apathetic. With cessation of voluntary motion, the patient may also suffer from dehydration, inanition, circulatory disturbance, and hypomyotonia.

Psychodynamics

Present understanding of the sharply contrasted behavior of manic depressive patients has been derived from Freudian concepts. Alexander has stated that although the manifestations of the depressed phase are exactly opposite to those of the manic phase, "the two are related as a convex arch to a concave." The attitudes change because rejected impulses, particularly the hostile and aggressive ones, are managed differently by the ego. In the depressed phase, hostile impulses are turned inward as a result of guilt feelings. In the manic phase, the hostile impulses are extroverted because the restraint of the superego is ignored. According to Alexander, manic depressive reaction is a disease of the conscience in which a cycle is established. Each state is both the cause of the successive state and the effect of the previous one. Thus, a continual conflict exists between the ego and superego. When, after the depressed phase, the patient has atoned in suffering for his guilt, his balance is restored and he may then disregard the discipline of the superego. This process may be related to the conceptual association of pain and pleasure, punishment and reward, transgression and expiation. These ideas, in turn, are analogous to the infantile experience of hunger and satiety. Another current concept is that, in the manic phase, the patient attempts to defend against the punitive function of the superego.

Fenichel has stated that " . . . the manic-depressive patient is ambivalent toward his own ego. In depressions he demonstrates the hostile element of this ambivalence. Mania brings to the surface the other aspect of this ambivalence; his extreme self-love." The self-directed hostility of the depressed patient results from introjection of an ambivalently regarded love object which becomes equated with the ego. For example, hostile aggressive feelings toward a love object are untenable and, therefore, result in feelings of guilt. Identification of the object with the ego provides the basis for self-depreciation. Thus both object and ego are lost, since they are castigated as one by the superego, and "loneliness and emptiness" are frequently described. The superego has a dual function, one aspect of which is protective, the other punitive. In depression, the patient is subjected to punishment.

Narcissistic orientation is requisite to development of manic depressive psychosis. Depression is believed to result from injury to infantile narcissim, severe disappointment before the Oedipal wishes have been resolved, and repetition in later life of disappointing events. The disappointment may be actual abandonment, or a more normal event, such as the birth of a sibling. It is the reaction which is significant, not the cause. The primary depression establishes a pattern of reaction which continues into the future. Both the narcissism and the ambivalence have an oral libidinal organization. In fact, the sexual excesses of the manic patient have been described as an effort toward "incorporation of everybody."

Differential diagnosis

Such psychological factors are believed by most investigators to be operative in all cases of manic depressive reaction. In addition, hereditary

predisposition may be influential, as manic depressive reactions do recur in successive generations of the same family. The disorder occurs more frequently in women, usually after the age of 20. Metabolic and endocrine studies have not as yet established organic origin, nor have post mortem studies shown any somatic or neuropathological cause.

Since some of the signs and symptoms of manic depressive reaction may exist in other disorders, differential diagnosis is significant to treatment and prognosis. For example, a patient with early paresis may behave in a manner similar to that of the manic individual. A depressed paretic may evidence psychomotor retardation, and may attempt suicide. The diagnosis of paresis can, of course, be established by blood tests and spinal fluid examination. Impairment of intellect, defective memory, and disorientation are not present in the manic depressive reaction and are indicative of other disorders. Although temporarily inadequate intellectual function may result from the altered emotional state, the intellectual ability of a manic depressive patient is unimpaired regardless of the number of attacks sustained.

Differentiation between manic depressive reaction and schizophrenia is sometimes difficult, since periods of elation and depression are not uncommon in schizophrenia. Knowledge of the prepsychotic personality is useful in either instance. In the schizophrenic, hallucinations and delusions are frequent, as is intellectual and emotional deterioration. The depression of the schizophrenic seems to have no pronounced subjective feeling, in contrast to that of the depressed patient, and there is a discrepancy between mood and verbal expression. The excitement of the schizophrenic is seemingly unrelated to the environment, whereas the manic is greatly stimulated by his surroundings. The speech of the schizophrenic may be rapid, but his thoughts are disconnected and bizarre. There is usually some sort of sequence to the flight of ideas expressed by the manic patient. The humor and wit of the manic is generally contagious, and usually that of the schizophrenic is not. Finally, the affective state is different: manic depressives feel strong emotion in either phase, while the schizophrenic affect is diminished.

Treatment

The treatment of patients with manic depressive reaction includes such supportive measures as protection from injury, provision for adequate nutrition and hydration, hydrotherapy, and occupational therapy. Psychotherapy is most helpful during periods of remission. Specific organic therapy includes drug therapy, electric shock therapy, and prefrontal lobotomy. Shock therapy has been the treatment of choice for many years, with prompt relief of symptoms in a great many cases. Recently, tranquilizing drugs, singly or in combination, have been administered with successful results.

In 1942, Rennie reported a study of the progress of 208 patients with manic depressive reaction. The group consisted of patients first hospitalized in the years from 1913 to 1916. This period was selected in order to record as long an interval of time as possible. None of the patients was given shock therapy at any time. Recovery from the first attack occurred in 93 per cent of the group, and 79 per cent suffered recurrences. Both chronic cases and single attacks are uncommon and chronicity is more frequently reported in cyclothymic patients. The author stated that estimation of future recovery should be made with caution. The most favorable outcome was demonstrated in patients who had the initial attack between the ages of 21 and 30, the least favorable in those whose first attack occurred after the age of 50.

According to Munro, "The manic-depressive psychoses are self-limited disorders. The substantial majority pass to complete recovery." He stated that the favorable prognosis is, of course, dependent upon adequate supportive therapy, prevention of suicide, and judicious administration of electric shock treatments. Munro noted that the prognosis was not necessarily unfavorable for persons in older age groups, especially for those who have sustained previous attacks. Patients who do not recover develop a mild chronic invalidism.

Henderson and Gillespie concur in estimation of a favorable prognosis for manic depressive patients, particularly if the first attack occurs before the age of 40. The authors stated that patients with early attacks of either type may be cared for at home. Repeated attacks are likely to be longer in duration, however, and the patients should be hospitalized to receive more intensive therapy.

Arieti has remarked the recent decrease in the incidence of manic depressive psychosis. Statistically, the number of persons with this disorder has decreased by one-third in the past 20 years. Arieti observed that this decrease may have resulted from socio-cultural changes; that the psychodynamic conflicts which influence development of this particular form of psychosis are peculiar to an inner-directed type of society which has begun to disappear in this country.

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Hysteria

History of controversial concepts

● USAGE OF THE TERM *hysteria* derived from an ancient belief that the uterus moved of its own volition and thereby caused varied disorders in women. Aretaeus, in the first century, offered this description of uterine activity: ". . . it is moved of itself hither and thither in the flanks, also upwards in a direct line to below the cartilage of the thorax, and also obliquely to the right or left, either to the liver or spleen; and it likewise is subject to prolapsus downwards, and, in a word, it is altogether erratic." Hysteria, according to Aretaeus, resulted from rapid ascent of the uterus which compressed the intestines and caused the carotids to contract "from sympathy with the heart." The patient thus became insensible.

At the beginning of the Christian Era medical knowledge had not progressed notably beyond the tenets expressed 400 years before by Hippocrates. His discussion of hysteria differed from the ancient concept only in that he recommended marriage as the best remedy. In 30 A.D., Aurelius Cornelius Celsus compiled the treatise "De medicina," which has been described as the first important book to appear after the writings of Hippocrates. Since Celsus was not a physician, presumably much of his material was simply extracted from previous works, including those of Hippocrates. In his book, Celsus described hysteria as the prostration and insensibility of a woman. He likened the manifestation to epilepsy except that convulsions were absent and, in hysteria, the cause was uterine wandering. As treatment methods Celsus recommended fumigation and a procedure similar to curettage.

Approximately 100 years later, Soranus provided an excellent description of the anatomy and position of the uterus, details of which have led several historians to believe that he did not approve the traditional theory of uterine migration. According to Veith, however, Soranus differentiated hysteria from catalepsy, epilepsy, apoplexy, and affliction with worms by the statement that hysterical suffocation "always involved an ascent of the uterus." Soranus's opinions are available at present only in the translations made by Caelius Aurelianus, c. 400 A.D. Galen, 130-200 A.D., did not accept the theory of uterine peregrination but he did believe that hysteria resulted from a kind of engorgement of the uterus.

The concept of physical origin of hysteria persisted for over a thousand years. Veith has pointed out that it was probably fortunate for the afflicted women that this belief did continue, since, otherwise, they would undoubtedly have been subjected to the torture administered to persons believed to be obsessed.

In 1682, Thomas Sydenham (1624-1689) responded to a request from his colleagues by publication of his concept of hysteria. In a paper entitled, "Dissertatio Epistolaris," Sydenham stated that hysteria was caused by "the faulty disposition of the animal spirits." He explained that imbalance of "animal spirits" disturbed the mind-body relationship with resultant disorder in the part of the body that is weakest at the time. Sydenham listed a multitude of complaints, including afflictions of internal organs, external parts, and even toothache as sometimes hysterical in origin. In addition, he stated that the same manifestations were observed in men. Sydenham was not the first to express this idea. For example, in 1618, Carolus Piso (Charles Lepois, Charles le Pois) remarked that hysteria originated in the brain, and, therefore, both men and women were subject to the disorder. Apparently, however, the term hysteria, from the Greek *hyster* meaning uterus, was generally considered applicable only in its literal sense, and, therefore, could not be used to designate disorders in men. Sydenham avoided this criticism by the statement that such disturbance in men is termed *hypochondriasis*, which word did not then have its present connotation. Again, this concept had been suggested before. Smollius, and others in the 17th century had written of uterine suffocation and *suffocatio hypochondriaca* as similar manifestations, caused by uterine migration in the first instance and obstruction of the spleen or viscera in the second. Sydenham differed, of course, in that he did not believe the cause to be organic. Sydenham's views on hysteria were not particularly well received by his contemporaries, nor were they accepted by subsequent investigators. Although he was honored as the "English Hippocrates," it was apparently also believed that his concept of mind-body relationship was "extreme" and better left unnoticed.

Sydenham's report was not the only one to be ignored. Several earlier investigators had suggested that hysteria might be sexual in origin, or might be a form of mental illness. For example, Paracelsus (1493-1541) had suggested the term *chorea lasciva* and implied a sexual origin of hysteria. He stated that an opinion or idea might cause the disease either in adults or children. About children, he said, ". . . their sight and hearing are so strong that unconsciously they have fantasies about what they have seen or heard." Weyer (1515-1588) had deplored the then popular reference to *stiqmata diaboli* and had insisted that the areas of anesthesia so designated were actually representative of a form of mental illness.

In the years that followed Sydenham's report, a number of theories of the cause of hysteria were offered. Francois de Sauvages (1706-1767) suggested that attacks of epilepsy and *grand hysterie* were both simulated, and he did not distinguish between the disorders. Later physicians considered them to be related and the term *hystero-epilepsy* was commonly used. Pinel (1755-1826) described hysteria as a functional, vegetative neurosis. Marchand, in 1847, stated that anemia was the cause of hysteria, even though Lange, almost 300 years before, had separated the anemias as a classification from the hysterias.

Charcot (1825-1893) used the term hystero-epilepsy although at the same time he stated his disbelief in any similarity of cause in hysteria and epilepsy. Charcot was aware of psychological factors in hysteria, but apparently he also thought the origin to be essentially organic. For example, in 1887-1888, he wrote, "It is to the ovary and the ovary alone that one has to look for the source of the fixed iliac pain of hysterics." The term *ovarian mania* became popular, and this concept resulted in a surgical approach which was shortly condemned, as had been such therapies as fumigation, blood letting, ice applications, and mesmerism.

While Charcot taught at the Salpetriere, Bernheim (1840-1919) was doing similar work at Nancy. Both men recognized the part of suggestion in hysteria but differed in their opinions of the incidence and the therapeutic use of suggestibility. Bernheim's studies included thousands of individuals and, from his observations, he concluded that suggestibility was an almost universal characteristic. Furthermore, in contrast to Charcot, Bernheim contended that, "the therapy of hysteria is not suggestion but de-suggestion." He believed that therapy should first bring forward whatever idea underlies the patient's illness and then be directed toward resolution of both the causative idea and the resultant symptoms. In this thesis, Bernheim anticipated, in part, the teachings of Freud.

Freud (1856-1939) studied with Charcot at the Salpetriere and observed the work of Bernheim and Liebeault at Nancy. Several aspects of this experience impressed him, and one was the evidence that under hypnosis a hysterical patient would talk freely not only of the symptom but also of the emotional factors associated with its development. Secondly, he recognized hysteria as a morbid entity rather than a product of simulation, and, finally, that the disorder was not limited to women. Freud returned to Vienna and presented his conclusions to the Vienna Medical Society. His listeners were particularly offended by the statement that hysteria occurred in men. They informed him that he spoke "nonsense"; that since the term referred to the uterus, it was impossible for a man to be hysterical. Freud responded by presentation of a male patient with hysterical hemianesthesia, after which, according to Brill, he was excluded from the laboratory where he wished to study and was unable to obtain a lecture room.

In 1895, Freud and Breuer published a book entitled *Studies in Hysteria* in which the "cathartic method" of treatment was described, whereby the patient experienced a mental and emotional purging. Freud later explained hysteria as the result of a repressed idea which continues to be active and, finally, is expressed by conversion of psychic energy into a physical symptom.

According to Freud, "Throughout life the ego remains the great reservoir from which libidinal cathexes are sent out on to objects and into which they are also once more withdrawn, like the pseudopodia of a body of protoplasm . . . A characteristic of libido which is important in life is its *mobility*, the ease with which it passes from one object to another . . . There can be no question that the libido has somatic sources, that it streams into the ego from various organs and parts of the body."

In a recent study (1952), Robins and others reported a comparison of hysteria in men and in women. Since the authors were unable to find a male patient with hysteria in either of two large civilian hospitals, they conducted their investigation with 38 patients from military and Veterans Administration hospitals where the term *conversion reaction* was used instead of *hysteria.* Four of the patients were civilians; 13 were veterans; 20 were soldiers; and one was a coastguardsman. Twenty-five women with hysteria formed the comparative group, and 39 (24 soldiers) healthy men were control subjects. The authors found several features that distinguished hysteria in men from hysteria in women. For example, in every instance of male hysteria some form of immediate personal gain, such as discharge from service or monetary compensation, resulted from the illness. In the women, no obvious gain was evident. The recital of symptoms was contrasted: the women were dramatic and verbose in describing symptoms, and the men were not. Because of these and other dissimilarities, the authors question whether the hysteria manifested by men is the same disorder that afflicts women.

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Paul Ferdinand Schilder

● Paul Ferdinand Schilder has been called the synthesizing genius of psychoanalysis. Schilder's study of philosophy, especially the phenomenology of Husserl, established the foundation for his later synthesis of interest in physiology and psychology and for his clinical application of ideas of the Gestalt school of psychology.

After receiving his medical degree in Vienna in 1909, Schilder became an assistant to Gabriel Anton at Halle, where he served until 1912. Schilder published his first article, on neuropathology, during his student days. While assisting Anton, he made his first observations on encephalitis periaxialis diffusa, later known as "Schilder's disease". At Leipzig he published a paper on symbolism in schizophrenia, in 1914, and his book, *Selbstbewusstsein und Personlichkeitsbewusstsein* came out that year.

Schilder became acquainted with Freud and heard many of his lectures. In his own writings he replaced Freud's "unconscious" with what he called the "sphere." Schilder himself considered his concept of the body image to be his own major contribution to neurology and psychiatry.

Schilder came to New York in 1930 as clinical director of the psychiatric division of Bellevue Hospital and research and associate professor of psychiatry of New York University Medical School. There he continued his studies on consciousness, based on psychiatric and psychoanalytic data.

Schilder brought to his younger American colleagues an expanded understanding of some of the philosophical presuppositions which underlay their own work. He himself rejected a mechanistic theory of psychology in favor of an organismic theory which recognized the importance of meaning and purposiveness to personality structuring. He said, ". . . desires and instincts cannot be understood as mechanical agents . . . they have aims and purposes." Paul Schilder believed neurotic symptoms cannot be understood if they are considered to exist in isolation; therefore the importance of individual social orientation deserves emphasis. He ascribed primal importance to meaning and conceptual purpose in the inner life history of the patient, and related neurotic symptoms to the real ideologies in the patient's life. Schilder synthesized Brentano's act-psychology (intentionalism) and Freud's drive-psychology, so that many of his ideas have been incorporated into what is now called social psychiatry. With Lauretta Bender, whom he married four years before his death, Schilder was able to practice his therapeutic principles in their work with children at Bellevue Hospital.

David Rapaport, who translated some of Schilder's major works, and who was selected to give the memorial address to the Schilder Society in 1951, has formulated Schilder's point of view in a series of concepts:

1. The human organism is always, at least potentially, a social being, directing toward a world of real objects.
2. "Drive-intendings arise from somatic apparatuses and structuralize into psychological apparatuses."
3. A behavior phenomenon may come about either by a physiological or a psychological process. This is Schilder's "principle of the double path."
4. Pathological forms of thinking result from their premature arising from or their unbalanced development in the sphere (the image with which Schilder replaced Freud's concept of the unconscious).
5. Nothing in psychic life is random or without motive.
6. The body image is a concept by which the individual structures himself and is structured, both physiologically and psychologically. Schilder's view probably grows out of Freud's formulation that "the ego is primarily a body ego."
7. Memory traces of experience are indestructible; and, furthermore, repressed memories often manifest themselves symbolically.
8. The self, knowledge of other people's feelings, and other experiential data are psychological facts that are not further reducible.

Rapaport calls Schilder an unsystematic genius whose speculations anticipated later developments in psychoanalytic theory and whose insights have by no means even yet been fully explored. Ironically, Schilder himself was a victim of the mechanistic aspect of society which he denigrated. It is said that he often crossed Times Square in the rush hour against a red light. On one arm would be a stack of books piled to his chin; the other hand he would hold up to stop traffic. On December 8, 1940, when he was fifty-four years old, he was struck by an automobile and fatally injured. Lauretta Bender, who continues their important therapeutic work, is noted for studies on the dynamic psychopathology of children.

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ULCERATIVE COLITIS

Influence of personality structure in origin and persistence of disorder

● "THE COMPLEX of melancholia behaves like an open wound," Freud wrote. In the extensive studies by Engel of ulcerative colitis, there was discernible in each patient the unhealed wound, so to speak, of a disrupted relationship with a key figure, usually a parent. The common emotion was one of despair, related to a sense of personal worthlessness.

Engel's studies were made to determine conditions that might be contributory to development of ulcerative colitis. While such conditions may not be sufficient to induce disease, the possibility exists of their being influential or indeed even necessary to such development. Like the epidemiologic approach to the study of malaria, which includes material about geography, climate, and breeding conditions of mosquitoes, in this type study clarification of the circumstances in which ulcerative colitis occurs is attempted. It is not asserted that psychologic processes are causative. Instead, the suggestion is offered that since certain patterns of behavior and particular emotional attitudes are regularly found in patients with the disease, their function in the etiology might justify further research.

The significance of the psychologic factors is often dismissed, just as the importance of the typhoid bacillus was, at one time, on the basis that many persons who were exposed to the organism did not die. Such a position, according to Engel, ignores the vulnerability of the patient.

Personality structure

Patients with ulcerative colitis commonly have well-defined traits that include obsessive-compulsive neatness and rigid attitudes toward morality. Obstinacy, querulousness, conformity, meticulousness of speech, and defective sense of humor are characteristic. Patients are said to be cautious, sexually immature, ingratiating, and uncannily perceptive of hostile or rejecting attitudes. Such individuals are often admired for their punctuality, conscientiousness, and orderliness. In interpersonal relationships the consistent pattern is one of closeness to only one or two persons, with, ordinarily, extreme dependence upon a parent or parental figure. It has been implied that such an individual seems to live through the maternal figure, acting out the wishes or ambitions of the parent.

Even in the descriptions of mothers by patients a fairly constant type of personality was discernible. The maternal figure was dominant and controlling, of the perfectionist type, and often gloomy and martyr-like in temperament. Men patients apparently found these traits more acceptable than the women did. Fathers of the patients were described as shadowy stereotypes, gentle, kind, and passive, although often abusive to their wives, with whom they identified. Often the male patients had been considered effeminate by their fathers. Women patients complained that their fathers were not sufficiently protective.

Sperling studied children with ulcerative colitis and reported the mothers to be rigid and non-maternal with strongly ambivalent feelings and unconscious destructive tendencies. She referred to the mother-patient relationship as "emotional symbiosis."

In adult patients sexual experience was characterized by frigidity on the part of the female patients, and indifference in the men. Clark found that patients had few relationships that were "comfortable," and that ability to form new associations was limited. This investigator commented upon inadequacy of defenses against anxiety in patients with colitis, and described defective development of ego independence.

Events at the time of onset of disease were found to be informative in many instances. Investigators found that within a few hours or days of the first attack most patients reported a severe traumatic disruption of a significant relationship—usually with a mother or mother substitute. Sometimes the relationship was ended by death, in others by rejection, but in each instance the relationship had been characterized by what Clark considered to be a "persistent or compulsive seeking of an infantile type of identification."

After disruption of the close relationship, the emotional sequence includes sensations of emptiness, and of loss of future, combined with severe depressive feelings and infantile fantasies of revenge and aggression. The emotional meaning of the disease to the patient can be ascertained by a review of familial or environmental circumstances at the time of onset of symptoms. Sometimes the patient represses or denies the meaning to himself of the lost parent or friend. In Clark's opinion, a substitute identification with another person or with a group may lessen or delay an attack.

Such a substitution or psychologic replacement is the treatment proposed by Clark, although he warns that during early stages the patient will remain as vulnerable as before to separation from the parental surrogate. In fact, any threat of disruption may bring about a return to emotional isolation and relapse. Engel summarized in three types the emotional stresses that were possibly precipitants: first, the real, fantasied, or threatened interruption of an important relationship: second, a situation in which demands were made upon the patient which he felt incapable of fulfilling; and third, threat from or disapproval by the parent figure.

In a case cited by Clark the patient was a seventeen-year-old boy who had been rejected by both parents. He experienced his first attack after an automobile accident, when his parents' disapproval of his "irresponsibility" amounted to a final rejection. The patient was hospitalized for three months and, during that time, a friendly relationship was established with the physician. The boy had

characteristically been unable to plan for the future during his illness. With the confidence that he developed through friendship with the physician, the patient was able to leave the hospital and to make plans for college. After two years, follow-up letters indicated that the boy had maintained good health and had established himself securely in his college environment. He commented that confidence in his ability to make friends in college was a result of the period that he spent in the hospital.

Apparently, there is also considerable correlation between the severity of the attack or relapse and the hopelessness of the patient. The words used by patients to describe their situations as they interpret them were revelatory of typical attitudes. The terms reported as used were *humiliated*, *defeated*, *powerless*, *lonely*, *hurt*. The subjects did not evince anger except temporarily and with helplessness. Helplessness, actually, appeared to be the characteristic reaction.

In many instances, attacks of ulcerative colitis were not the only somatic reactions of the patients. Several complained of headaches, some of which were of migraine type and of great severity. Engel observed that some patients responded to conflict situations with other neurotic, psychotic, or psychosomatic reactions when ulcerative colitis did not develop.

Szasz emphasizes the importance of oral-incorporative strivings in instances of colonic disturbance. He points out that mobilization of strong unconscious strivings would result in constipation, and that a sudden decrease in striving because of guilt would bring about diarrhea. Accordingly, he interprets the symptoms referable to the bowel as without any primary psychologic meaning. Instead they are considered as manifestations of a vegetative neurosis, the physiologic accessory to the patient's oral tensions. Because of the established connection from the psychodynamic point of view between the assimilative process and the mother-child situation, it is not surprising that in all types of gastro-intestinal disturbances the factor of oral tendencies is to be considered.

Organic changes

Besides dysfunction, actual tissue change occurs in ulcerative colitis, of course, and studies have also been made of the major psychologic phenomena evident in patients with demonstrable tissue alterations. Again, a real or threatened disturbance in an important relationship was typical, with an affective state characterized by the helplessness consequent to such a separation. In Engel's opinion the broken relationship is traumatic, and the accessory biochemical or physiologic derangements permit initiation of any of a variety of pathologic processes. He also believes that it is possible that colitis may be a symbolic transformation of grief.

The differences between grief and melancholia are interesting in this context, because of the disposition of the individuals who evidence one or the other. The personality that develops melancholia is basically narcissistic, according to some investigators. Reviews of reports of more than 700 cases would seem to indicate that the patients' personality defects antedated the beginning of ulcerative colitis, and that the individuals manifested a particular kind of dependence, as well as failure to achieve heterosexual development. Although both onset and relapse could be related to real or prospective loss of a figure emotionally significant to the patient, the investigator concluded that disease ensued only when the corresponding effect was that of helpless despair. The choice of organ is assumed, by Engel, to be explained on a basis of both constitutional and experiential factors in the patient's relations to the parental figure.

Since patients with ulcerative colitis may require both psychotherapy and medical treatment, cooperation between psychiatrist and physician is important. The psychotherapeutic management is supportive, since probing into the emotional conflicts can cause an exacerbation of symptoms severe enough to produce a medical emergency. Equally important is mutual recognition of the crucial quality of interpersonal relations to this type patient, and the possible resultant pathological dependence. In one cited case the continued possession of an unfilled prescription constituted for the patient a sort of magical bond, sufficient for reassurance that the relationship to the physician had not been severed. Knowledge of a telephone number at which the physician may be reached when he is out of the city may in some instances provide enough reassurance to prevent an attack.

Another form of therapy is effected by alteration of the patient's home situation, at least temporarily. For example, a six-year-old patient experienced his first attack shortly after the birth of a brother. Diarrhea ceased when another brother went to visit their grandmother, and resumed when he returned. The major objective of alteration therapy is to effect a substitute relationship which can become a maturing experience.

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Fantasy Life of Children

Fantasy is a normal activity that may be increased by overactive imagination or by inadequate environment.

● THE DAYDREAMING CHILD has in the past been the cause of dismay of parents and frustration of teachers. In recent years, however, social attitudes toward daydreaming and fantasy life have altered. This change has developed as a result of studies to compare the fantasy life of normal and deviant children, and of superior and retarded children. If, as Isaacs points out, "Phantasies are the primary content of unconscious mental processes," it is obvious that a study of the fantasies of any child will tell a trained observer something of the content of that child's mental processes and attitudes, many of which may not have been verbalized.

Fantasy may be evidence of ego strength or of childish efforts to compensate for an unsatisfactory reality. It may be interpreted as an effort at preparation for action in the real world through experimentation in fantasy. Less favorably, fantasy may be considered a regression to a more pleasurable, primitive experience. In any case, modern writers agree that daydreaming does not represent a deliberate, conscious effort on the part of the child, but is rather an attempt to mold unfavorable reality into an image which is more suitable to the individual needs.

It is not surprising to find that a high percentage of children who have no siblings resort to creation of imaginary playmates as do children who are far removed in age from other siblings. Also, children whose relationship with their parents is unsatisfactory and those with no real playmates tend to utilize this device, and seek, in the creations of their imagination, the love and security they have not found in their environment. Childers found that the child who is isolated from his parents, either physically by absence, or emotionally by prolonged disapproval is the type who has a tendency to hallucinate.

In families in which conditions seem normal or even favorable, highly gifted children often create for themselves imaginary companions and a rich fantasy life besides. Bender suggests that this may be because their needs are greater than those of the average child. In fact, in the opinion of Svendsen, about 13 per cent of all children have "vivid and sustained" imaginary companions. According to Jersild, the higher the intelligence quotient of the child the more likely he is to be able to describe clearly his fantasy companion.

Imaginary companions usually appear to children between the ages of three and six. Murphy suggests that children often absorb stress and react to it in non-verbal ways, up to the age of three, when their reactions appear as fantasy as their language facility develops. From three to four, a child may have difficulty differentiating between real and imaginary experiences; he may, in consequence, develop anxiety about some aspects of adult-supplied fantasies, such as the wolf in *Little Red Riding Hood* or the witch in *Hansel and Gretel.* The child's own fantasy creations may be more violent and aggressive in nature than the storied characters and yet not arouse anxiety. Perhaps the child knows his own wolves and witches are fantasy. Bender points out that the child's fantasy helps him to assimilate troubling experience.

Imaginary companions may be boy or girl playmates or favorite or imagined toys given life. Examples abound in literature of such experiences as in Stevenson's "*My Shadow*" and Milne's *Winnie the Pooh.* From four to six, the child enjoys, usually without anxiety, the myths and fairy tales which are the traditional and acceptable method of fantasying in our culture. At six, unless an unsatisfactory environment persists, children often lose interest in their imaginary companions. Perhaps the beginning of school life provides the

needed companions, or perhaps formal education tends to discourage or repress the creative imagination.

Svendsen found an apparent connection between fantasy and mild personality difficulties, especially timidity. This finding supports Bender's view of the function of fantasy in the personality development of the child as a positive, constructive effort to make up for certain deficiencies of the environment.

Earlier opinions that daydreaming might indicate a tendency to schizophrenia were refuted by Thetford, who examined at three age levels a schizophrenic group and a normal control group from the Chicago public schools. The age groups were from six through nine, ten through thirteen, and fourteen through seventeen. He found that the schizophrenics had a quantitatively greater fantasy life than children in the normal group at the two younger age levels, but that during the adolescent period there was little difference between the two. He concluded that the "schizophrenic child has to make an earlier initial and not lasting effort to survive." He found that normal adolescents were more actively "expressive of themselves," whereas the schozophrenic adolescent is "more passive and submissive than his normal peers." Schizophrenia indicates failure in these cases of the ego-strengthening effort indicated by the earlier rich fantasy life. Bowman in his studies of the pre-psychotic personality found that normal persons daydreamed more than schizophrenics in a ratio of almost two to one.

There seems to be general agreement that hallucinations and daydreaming strengthen inadequate reality, becoming pathological only if the fantasies do not satisfactorily connect a child's needs and reality. Important clues to experiential causes of disturbance are often revealed in the fantasy life of the disturbed children, and the progress of these children toward normality can usually be traced through changes in play.

Mention has been made of the nursery rhymes, fairy tales, and myths by which our culture supplies children with ready-made fantasy. Another external supply of folk lore utilized by the child for ego-strengthening purposes is made available through comic books and strips, which are not an adverse influence but provide a supplementary fantasy life. Bender says that a child interprets the story in terms of his own experiential needs, so that there are as many interpretations as readers.

"If the child seems to react with some emotional or behavior disorder to reading the comic books, the reason predisposing him to the trigger action it supplies lies within the child and should be sought out. It is evident from our own case studies that whatever anxiety, aggression, or confusion might be attributable to comic books could better be traced further back to the basic traumatic factors within the children's background," according to this physician.

Although Bender agrees that the full significance of the creation of imaginary companions in the normal psychology of the child has not been definitely evaluated, she states unequivocally that imaginary companions and fantasy life represent a positive and constructive effort in the personality development of the child to compensate for some environmental deficiency. This lack may be an unsatisfactory parent-child relationship or an unsatisfactory social or economic situation. Fantasy, she says, is integrating behavior, and it represents the child's normal effort to resolve his difficulties. In fact, according to Bender, the presence of imaginary playmates indicates ego strength and is reason for hope that the child's personality difficulties may be overcome. The physician with these facts may reassure parents who are troubled because their child has created a Harvey-equivalent. In fact, the physician may help the parents to learn from their child's fantasy life what environmental factors trouble him and should be rectified.

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ISOLATION

A lack of sensory stimuli causes intellectual dysfunction. This effect is dramatically demonstrated in brainwashing techniques.

" . . . and I walked and walked in the rain that turned half into snow and I was drenched and frozen; and walked upon a park that seemed like the very pasture of hell where there were couples whispering in the shadows, all in some plot to warm the world tonight, and I went into a public place and saw annunciations drawn and written on the walls. I came out and felt alone and lost in the world with no home to go to and felt robbed of everything I never had but dreamt of and hoped to have; and mocked by others' midnight victory and my own eternal failure, unnamed by nameless agony and stripped of all my history, I was betrayed again."*

William Goyen in these lines speaks for all those whose separation from other human beings has become a major factor in their lives. The feeling of separateness is so prevalent today, as our best modern novels attest, that isolation or alienation has been called the modern predicament. Isolation is significant, however, not merely because it makes modern man uncomfortable, but because, in extreme cases, it severely warps the personality and lowers mental efficiency. The experience of isolation is invariably a part of the personal background of disturbed individuals, such as the bored, neurotic, alcoholic, delinquent, or the schizophrenic. Significantly, isolation has become a part of the techniques of modern warfare.

The person who has been isolated, either physically or emotionally, from parents, peers, or community tends to see a distorted world and to be unable to function at full capacity. The effects are to be seen in the attitudes of individuals who have experienced only a degree of isolation, such as a highly restricted intellectual or moral environment. John Cohen says such persons are crippled in inventiveness. According to this investigator, inventiveness and the kind of creativity necessary for original thinking or for problem-solving depend upon the experiential scope of the individual and upon the related factor of flexibility. Rigidity of environment results in compartmentalization of thinking, because it fosters

*From *The House of Breath*, by William Goyen, New York, Random House. Copyright 1950. Quoted by permission of the author and publisher.

attitudes of guilt, fear, prejudice, or shame, all of which impair lability in mentation. The greater the scope of an individual's thinking, the greater is the likelihood of what Poincare called "the collision of ideas."

The significance of range and flexibility in human mentation has an obvious bearing on types and methods of education. Modern education has to serve as preparation for business, for the professions, or for meeting the needs of the nation. The effect of isolation in decreasing flexibility was dramatically demonstrated in two recent experiments, one with animals and the other with human subjects.

Thompson and associates utilized varying degrees of isolation with Scottish terriers, and then tested them against a control group to observe the effects of such rearing on ability to learn and on capacity to solve problems. The dogs reared in complete isolation showed surprising incapabilities when compared with terriers from the same litter who were reared in open kennels, and who were petted at regular daily intervals. The dogs reared in isolation showed marked hyperactivity which, along with their inability to solve problems, was still in evidence two years after they had been removed from isolation.

A similar experiment was performed by Heron and others with volunteer college students as subjects. Their findings indicated that even at maturity the human being is surprisingly dependent upon his environment for the maintenance of mental efficiency and for his personality structure. In this experiment college students were asked to remain in isolation and to do nothing for as many twenty-four hour periods as they could sustain the conditions. The subjects had comfortable beds in cubicles that were partially soundproof. They were required to wear frosted plastic goggles, which made it impossible to distinguish pattern, and pasteboard cuffs to limit tactile sensation. The intelligence and ability of each subject were tested before he entered his cubicle and tested again when he emerged. Most of the subjects were unable to tolerate the circumstances for more than 72 hours.

As the period of isolation lengthened, the students displayed increasing irritability. They began to daydream and then to have hallucinations, which were at first only mental, then visual, and, finally, aural. When isolation was terminated, the subjects all expressed increased belief in supernatural manifestations. They had become extremely suggestible and spoke of feelings of "otherness" as if their own bodies had become dissociated. The cited symptoms seemed in many respects to be similar to the effects produced by mescal. Perhaps most surprising was the marked decrease in intelligence quotient and in ability to solve the same types of problems that they had been able to solve quickly before isolation.

According to Hebb, results of these experiments are dramatic in that the statistically significant losses in problem-solving functions indicate that the higher mammal may be more dependent psychologically upon his environment than we are accustomed to consider him. Hebb states unequivocally that psychological development or emotional maturation is fully dependent upon stimulation from the environment. In the opinion of this investigator, both loss of ability to solve problems and actual personality alteration can develop after even a brief period of sensory deprivation and loss of social interchange.

Not only depression and anxiety, but delusions and hallucinations are described by many individuals who report experiences of isolation on the sea or in the far north. Christine Ritter, who was alone in the Arctic for periods as long as sixteen days, reported in "A Woman in the Polar Night," that she saw a monster, heard ski sounds although no persons were to be seen, and that at times she imagined herself as being devoured by the moonlight, indeed as being moonlight herself. From Solomon's observations it might be concluded that the imagination attempts to create for the individual whatever is lacking in his situation. So many who spend the winter in the polar regions reported such visions that the Spitzbergen hunters have a term for them —*rar*, strangeness. Unable to tolerate a vacant world, the mind peoples the polar and sea wastes with its own fears or images of hope or beauty; it listens to its own music.

Tales of isolation at sea, like those of the polar night, abound with reports of apparitions, both helpful and menacing. John Slocum, while sailing around the world alone, was ill and restricted to his cabin during a gale. An apparition appeared and took over the tiller, reassuring him that it was a pilot and would come when needed. In the morning Slocum found his ship on its course, 93 miles nearer his destination.

The effects upon man of a rigidly restricted environment, and of isolation from sensory stimuli have been utilized by both Russian and Chinese Communists. Lifton believes the successful manipulation of prisoners' thought processes to have been enhanced by control of the environment. The increased suggestibility of individuals subjected to isolation provides a powerful means of control. In the unscrupulous, it is a weapon of frightening potentiality.

It was the intent of the Chinese Communists to make prisoners into a group of "social isolates," according to Lifton and Schein. To accomplish this purpose, any individual with qualities of leadership was removed from the group, the members of which became increasingly suspicious of each other. The social and emotional isolation prevented interaction, so that ultimately attitudes and values lost all meaning.

Studies by Wahl indicate that physical separation of a child from its parents also has far-reaching effects upon personality development. It is well known that the separation of a young child from its mother constitutes a traumatic experience. Wahl found indications that separation from the father is equally traumatic, and that it is true of adolescents as well as babies. In his examination of the family backgrounds of 392 schizophrenics, of all humans the most isolated, he found that 43 per cent had, before the age of 15, lost one parent or both. In each of the remaining members of the group there was a history either of parental rejection or oversolicitousness. As the latter is a reaction-formation to cover rejection, he concluded that such isolation of a child was a decisive factor in the development of schizophrenia, and that the relationship to the father is more important in personality development than has been realized.

In this group of schizophrenic patients there were no only children, and Wahl suggests that the dearth may be accounted for by the attention

and love usually given to an only child. Fifty-two per cent of patients in this group came from families of more than four children, so that the possibility of unequal distribution of parental love and attention may be considered, as well as the factor of sibling rivalry. The child whose parents are anxious, vacillating, or rejecting feels guilty of an unknown sin. He may believe that his parents consider him unworthy or wicked, and may become placating, withdrawn, or destructive, as illustrated in a case cited by Kanner.

The patient was an adolescent boy, rejected by his mother in favor of a younger child. In a sudden demonstration of revolt he wrecked family belongings and furnishings. A psychiatrist was summoned but on his first visit he found that the mother had also called in the police, to whom she spoke of her son as a "bad boy." The child's step-father, an army officer, reported that the boy behaved well when he was on trips with him.

Subsequently, while the father was away on active duty, the boy was put into boarding school at some distance from his mother. The mother, however, decided that she could not endure separation from him, and moved close to the school where the boy had functioned well, and made friends among students and teachers alike. Here the former pattern was resumed. The mother repeatedly warned the headmaster and teachers of the boy's "destructiveness" and constantly enjoined them to watch him. Soon the atmosphere of friendly acceptance, in which the boy had behaved well, changed to one of suspicion and distrust. Finally the boy engaged in a destructive foray similar to the one which had necessitated the initial call to the physician.

The situation was resolved by removal to another boarding school across the country from the mother, who was warned not to communicate her attitudes to the new school. There the boy again established himself successfully, this time for the duration of his school experience.

The most disturbed individual, even a schizophrenic who usually evinces no response whatever to his environment, is affected favorably by a consistent climate of interest and encouragement, according to Wahl. Regard must be sincere and, as Kanner points out, will affect the learning as well as other responses.

The basic personality is usually formed through human relationships within the family. The individual may be thought of as a point upon which his family, his peers, and his whole community come to focus their collective influences. These influences may be either supporting and integrating factors or disruptive forces.

The influence of the community is made evident in the incidence of juvenile delinquency. Adolescents often find no place for themselves and no acceptance in many communities. Isolation is an important factor in the distorted views of society developed by juvenile delinquents.

The artist, however, is probably the archetype of the isolated man in most modern American communities. The writer, painter, or poet suffers from the isolation of being "different" and from feelings of guilt and worthlessness, because in many instances his strivings and goals are rejected as valueless by his community until or unless he receives fame abroad. A recent study on Hawthorne (von Abele) ascribes his early death and distintegration as an artist to his feelings of guilt over having contributed nothing but his writings to his New England community. Melville, famous author of *Moby Dick*, wrote in his novel *Pierre* and in letters to Hawthorne of his feelings of isolation from his community.

It must be remembered that such feelings of isolation are not the concomitant of low intelligence but of imagination and of high mental capacity. According to Hebb, the greater the intelligence the greater the susceptibility to emotional disorder.

Fromm says, "The deepest need of man, then, is the need to overcome his separateness, to leave the prison of his aloneness." Fromm calls love the bridge or integrating force between persons or between man and society, and, "mature love is union under the condition of preserving one's integrity, one's individuality."* Only when he loves, says Fromm, does man lose his sense of isolation.

*From *The Art of Loving*, by Erich Fromm, Copyright 1956. Quoted by permission of Harper and Brothers.

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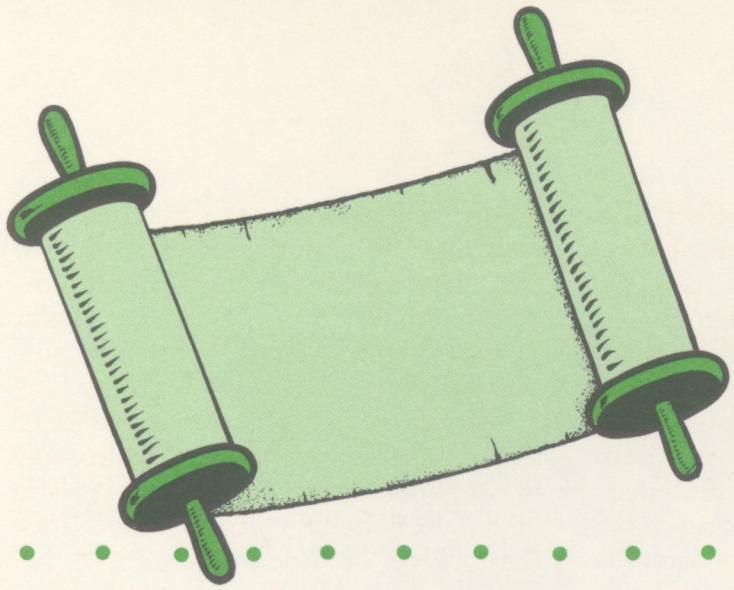


BOOK REVIEWS

THE MENTALLY ILL CHILD. *By Steven B. Getz, Ph.D., and Elizabeth Lodge Rees, M.D. Pp. 88. Price $3.50. Springfield, Charles C Thomas, 1957.*

This specifically directed monograph is subtitled "A Guide for Parents." Parental responsibility is sometimes made onerous by the common misunderstandings and errors attendant upon the subject of schizophrenia in children. This short volume is planned to clarify some of the nebulous theorizing on the subject, to outline the functions of the various organizations available for assistance, and to explain the legal and medical aspects of the problem. An illustrative case history is included, and there are sections on such pertinent topics as physical care, therapeutic modalities, and educational facilities. One of the authors is a pediatrician, the other a psychologist from a school for deaf children. Their approach is both practical and scientific. The volume has an index and bibliography.

YOUTH AND CRIME. *Proceedings of the Law Enforcement Institute held at New York University. Edited by F. J. Cohen. Pp. 273. Price $6. New York, International Universities Press, Inc., 1957.*

The papers presented here from eight sessions of the Institute, held July 18-21, 1955, had the common purpose of attempting clarification of problems in prevention and reduction of juvenile delinquency. The collection has predominantly to do with legal and sociological aspects of this problem, and the tabulated facts are impressive and alarming. A particularly telling contribution to this book, on the subject of predisposing factors, was given by Lauretta Bender, M.D., Professor of Clinical Psychiatry at New York University and Bellevue Medical Center, and Senior Psychiatrist in the Children's Service, in the Psychiatric Division of that hospital. The volume is fully indexed and references are included.

THE DOCTOR AS WITNESS. *By J. E. Tracy. Pp. 221. Price $4.25. Philadelphia, W. B. Saunders Company, 1957.*

The function of a physician who is asked in his professional capacity to participate in a legal procedure is not always clearly understood. This volume is planned to afford some explanation of the subject to practitioners who may be called upon for testimony. The author is a Professor of Law (Emeritus), and has written in clear and simple language an outline of procedures and problems and the reasons for their existence. The sixth chapter has to do with insanity and is particularly informative, as are the sections on compensation proceedings and charges of malpractice.

INTEGRATING THE APPROACHES TO MENTAL DISEASE. *Edited by H. D. Kruse, M.D. Pp. 393. Price $10. New York, Paul B. Hoeber, Inc., 1957.*

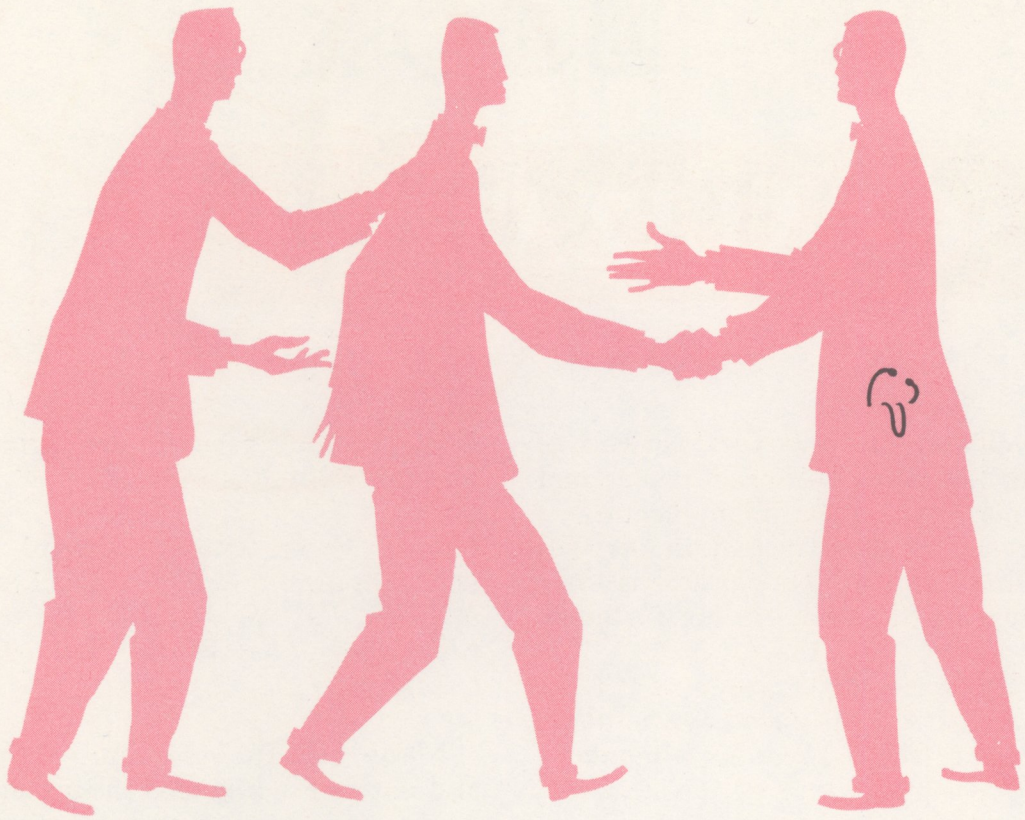
Four particular schools of thought as to the causality of psychiatric diseases may be categorized as the organic, experimental psychological, psychodynamic, and psychosocial. The Committee on Public Health of The New York Academy of Medicine arranged for two conferences on the subject to consider multidisciplinary procedures for further study and research on mental disease. In this volume are presented the papers and discussions of 48 participants at the two conferences, edited by the Executive Secretary of the Committee. Bibliographic references are included and the volume is indexed.

MAGIC, MYTH AND MEDICINE. *By D. T. Atkinson, Sc.D., M.D., LL.D., F.A.C.S., F.I.C.S. Pp. 313. Price $5. Cleveland, The World Publishing Company, 1956.*

Many colorful and unusual facts and names are included in this short, diverting history of the practice of medicine. The style is entertaining and the material well selected. Readers of the THE PSYCHIATRIC BULLETIN may particularly wish to read the account of Henry Cornelius Agrippa and the development of the practice of psychiatry, but they will find the whole volume both readable and informative. MAGIC, MYTH AND MEDICINE is indexed and has an especially interesting bibliography.

BEYOND LAUGHTER. *By M. Grotjahn, M.D., F.A.P.A. Pp. 285. Price $6. New York, The Blakiston Division, McGraw-Hill Book Company, Inc., 1957.*

The analysis of humor is the subject of this unusual book, some parts of which have been published previously in periodicals. Readers will be pleased that Dr. Grotjahn's papers have been collected in such attractive and highly readable form. Jokes, the act of the comedian, and the expression of humor in art and literature are discussed in this volume, and the function of laughter in our culture described. The communication made possible by laughter is an essential for resolution of some forms of conflict, aggression, and cultural repression, and this volume begin with a commentary on Freud's psychoanalysis of jokes, published in 1905. The volume is indexed and contains a splendid bibliography.



The Discharged Patient

The physician's responsibility to patients released from mental hospitals

● According to Gorman, "More than 250,000 patients are discharged each year from our state mental hospitals alone, yet the great majority of them are not followed up in the community." This lack of after-care has been cited as a significant factor in the re-admission of many patients. Furthermore, patients well enough to be released have remained in the hospital because no adequate provision could be made for care at home. In an effort to alleviate this situation, the American Psychiatric Association has organized a project for the purpose of interesting general practitioners in follow-up care of patients who have been mentally ill.

In a recent nation-wide survey, members of the General Practitioner Project observed the current practices and attitudes concerning the family physician's part in care of patients released from mental hospitals. The persons queried were the commissioners or directors of state mental health departments, and superintendents of state mental hospitals. From the information collected, these conclusions were made. First, it seemed to be generally agreed that the family physician is a most important potential source of help, whether he is directly concerned with the individual patients, or acts in an advisory capacity to the staff of special community clinics. In some states, a direct relationship between the hospital psychiatrists and the family physician is possible; in others, liaison can be achieved through social service workers, welfare organization workers, or public health nurses.

Second, the need for psychiatric teaching and experience for general practitioners was emphasized. Such teaching and experience would not only result in improved care of the released patient, but would be valuable to the physician in practice.

Finally, the timeliness of such programs was stressed. According to Goshen, the use of tranquilizing drugs has brought the general practitioner closer to the discipline of psychiatry than he has been at any time previously. As a result, many physicians have expressed a wish for further information about diagnosis, treatment, referral, and after-care of mentally disturbed patients.

Several states have planned programs that will include the family physicians in care of discharged psychiatric patients. For example, Booher reported the objectives of such a program in Indiana. The plan includes postgraduate teaching of general practitioners, postgraduate courses at the University of Indiana Medical School, and local classes on mental health subjects. In addition, communication between the hospital psychiatrists and the general practitioner will be encouraged by progress notices sent to the family physician while the patient is hospitalized, a case summary sent at the time of discharge, and the patient referred to him upon release from the hospital. It is also to be hoped that general practitioners may become interested in part-time positions on the staffs of mental hospitals. The shortage of psychiatrists is well known and this plan would also provide additional general medical care for mental hospital patients. Booher commented that this project is only a beginning and that many more plans are to be added.

Aldrich has pointed out that the patient's return from the hospital is a particularly crucial period in the process of his recovery. For this reason, the physician should plan the rehabilitation of a mentally ill patient with these facts in mind. First, the psychotic patient has been hospitalized because of failure to adapt emotionally to the demands of his environment. Second, his recovery has been achieved in a structured, protected hospital environment where he was cared for with understanding and encouragement. Finally, he must return to the same environment in which he had previously failed, "complicated now by the regrettable but currently almost unavoidable social stigma of mental illness."

The patient's family may have misgivings although they may have had adequate explanation of the disorder and may have learned to understand the patient. In many instances, however, they will be uncertain of their proper function, will be doubtful about the patient's conduct with outsiders, and, often, will fear relapse. These, then, are some of the problems which must be resolved in order to achieve rehabilitation.

The family physican's greatest help to the patient will be as a person who understands the problems of this adjustment. As the physician is more objective than the family can be, he

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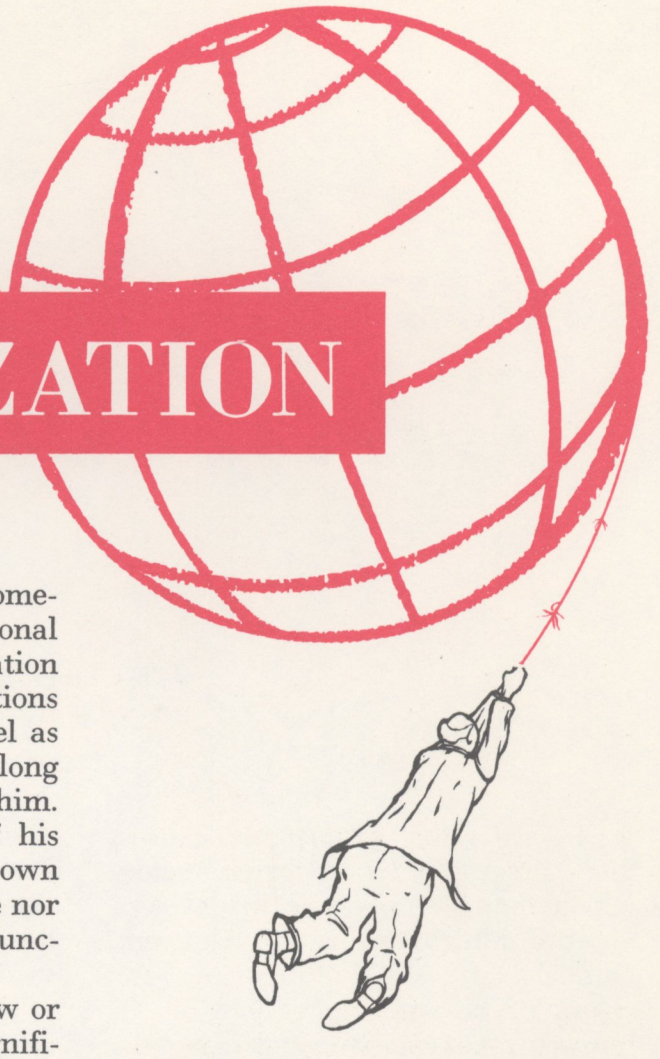
Bases for Psychiatric Referral:

DEPERSONALIZATION



● Depersonalization is characterized chiefly by feelings of unreality and detachment from the environment. In minor degrees, it is, of course, a relatively common experience, although it may be the first general sign that a patient's personal defenses have become perilously weakened. For this reason, recurrent or moderately severe feelings of depersonalization may be indicative of incipient neurosis or even psychosis. Such feelings may be prominent in the symptomatology of depression, hysteria, and in schizophrenia.

Overt manifestations vary in intensity, duration, and frequency. Feelings of unreality are, of course, associated with many physiological effects. For example, severe fatigue, faintness, hunger, high fever, drugs and anesthetic agents, and, sometimes, alcohol can be causative. In addition, factors such as prolonged exposure to noise or total silence, or motion sickness may precipitate these sensations. In times of danger, relatively normal individuals may experience sensations of loss of identity. The effects of sudden release from a dangerous situation were noted particularly during the war, in that soldiers who returned from active combat zones to safe areas often reported temporary feelings of unreality within their environment.

Evidence of depersonalization can be the precursor of a psychiatric disorder, although the clinical aspects differ somewhat with the individual patient. In some respects, the manifestations may resemble those of schizophrenia. Usually, the patient expresses a subjective consciousness of change. He may feel that he himself is different, even that he is someone else. Frequently, patients express the opinion that they move mechanically and automatically through the world, from which they are detached by invisible barriers. They sometimes feel incapable of any emotional or physical needs. This dissociation may be confined to certain portions of the body; the patient may feel as if these body segments do not belong to him, or are not controlled by him. He may even feel uncertain of his own sex. Patients have been known to insist that they can neither see nor hear, although no physical dysfunction can be established.

Evidence obtained by interview or from case history may have significant diagnostic and prognostic portent. Usually, depersonalization is preceded by hypochondriasis and a period of extreme self-observation. Under careful questioning, the patient may recall experiences of hallucinations and delusions. Usually, these occasions are only admitted with reluctance if at all. Such findings can be indicative of impending emotional illness, perhaps even of a complete break with reality.

Usually, the preceding period of self-observation is not as intense in depersonalized patients as in instances of latent schizophrenia. Certainly, the phenomenon of depersonalization occurs in patients with other mental disorders, besides schizophrenia. It may occur in individuals whose inhibitions are sufficiently strong to have prohibited the development of emotional maturity in personal relationships. Stress is more often a precipitant in persons with a relatively low level of personality integration.

Feelings of depersonalization may result from repression of intolerable conflicts, unconscious denial of temptations, rejection of a dominant person, or unwillingness to accept an unbearable situation. Rosen has reported a patient who, in early childhood, witnessed a suicide attempt by his mother. In this instance, the original trauma was reinforced by adult denial. The patient, as a young adult, developed marked symptoms of depersonalization, which were found in the course of intensive therapy to be related to this event. Ordinarily, however, the depersonalization syndrome is not severe and acute enough to justify specific diagnosis. It is in its close relationship to the psychotic and neurotic states that it is most significant. When the symptom becomes sufficiently severe for it to be mentioned to the physician, it is literally a danger signal. Like fever, the depersonalization syndrome is a general symptom and accessory to many disorders. It may be indicative of imminent disaster to the personality; therefore, the physician should not subject the patient to intensive questioning. Neither will he wish to temporize or reassure without basis. In general, then, in such instances, psychiatric referral is indicated.

Suggested Reading

Ackner, B.: Depersonalization, J. Ment. Sc. **100**:838 (Oct.) 1954, abstr. Digest Neurol. & Psychiat. **23**:130 (Mar.) 1955.

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Company Inc., 1945, p. 418.

Laughlin, H. P.: The Neuroses in Clinical Practice, Philadelphia, W. B. Saunders Co., 1956, p. 321.

Rosen, V. H.: The Reconstruction of a Traumatic Childhood Event in a Case of Derealization, J. Am. Psychoanal. Ass. **3**:211 (April) 1955.

Enuresis in Adults

This functional disorder may persist from childhood or may recur as a form of regression.

● In addition to organic causes, there are many psychogenic factors which may be operative in development of adult enuresis. Psychogenic enuresis in the adult can, for example, be one indication of an immature personality, or it may be a neurotic manifestation in an otherwise well-adjusted individual. Moreover, some investigators believe that the symptom is related to somnambulism and epilepsy.

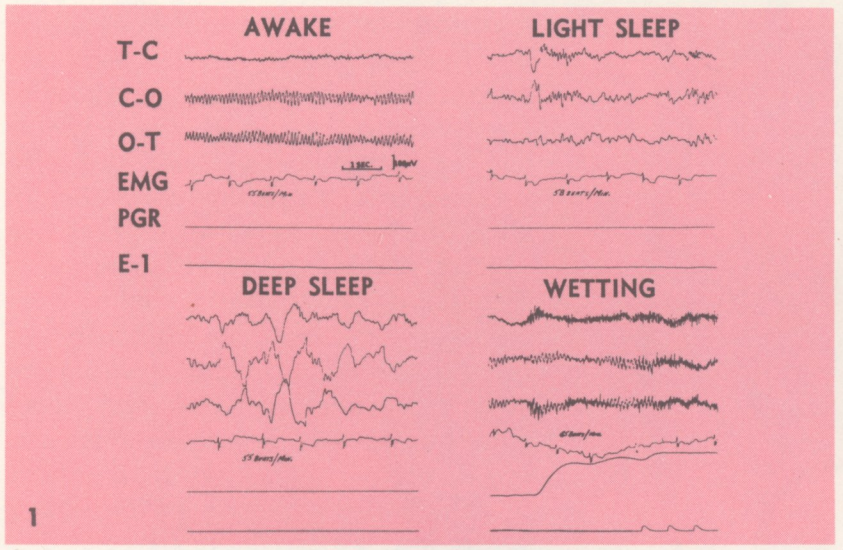
When enuresis has persisted into adult life, the patient's total personality should be evaluated for other evidence of immaturity. Although such personality factors may not be readily apparent, careful investigation will usually show maladaptation in interpersonal relationships, poor judgment, and inadequate tolerance of minor stress. The last of these characteristics may be the most prominent, as, in personalities of this type, minor stress causes emotional disorganization, disproportionate excitement, and ineffectual behavior. Even the usual anxieties and simple frustrations of a normal, daily routine are poorly tolerated. The reasons for this form of arrested emotional development, are, of course, individual. Usually, lack of independence and unstable orientation result from an early environment in which insufficient opportunity was provided for the resolution of dependency needs, and the parental attitude was overprotective.

Since enuresis, in such instances, is but one symptom of a basically immature personality, the therapy would, necessarily, be directed toward promotion of emotional growth and stabilization. The patient may benefit from psychoanalysis if his intellectual development is such that he can participate, and if there is evidence of sufficient ego potential.

When functional enuresis occurs in an adult who has previously maintained control since childhood, the symptom is considered to be a form of neurosis called *conversion reaction*. Conversion reaction, by definition, is an unconscious mechanism whereby an impulse which would otherwise cause anxiety is given symbolic somatic expression. Usually, the organ or part of the body involved is one that is ordinarily under voluntary control. The anxiety-producing impulses which may be converted into enuresis are almost unlimited in number. For example, distress because of masturbation may be averted by substitution of enuresis. Since enuresis is a form of infantile auto-eroticism, it may, as a later, uncontrolled manifestation, be unconsciously equated with masturbation. Enuresis in the male may result from an unconscious wish to urinate in a feminine manner. Hostility or aggression may be expressed in this way, or the symptom may represent a wish to return to the passive receptivity of infancy and, thereby, to avoid responsibility.

The psychoanalytic treatment of the patient with a conversion symptom is usually successful. The outlook is more favorable when enuresis occurs in an individual who has had control than it is when enuresis has persisted since childhood. In some cases, advanced age of the patient or, rarely, an intolerable underlying conflict for which conversion is the best solution, contraindicates psychoanalytic intervention.

The association of somnambulism, epilepsy, and enuresis was investigated in a study of 200 naval recruits. The subjects were men who were to be discharged from the service because of enuresis, and an equal number of recruits whose adjustment was satisfactory were interviewed as controls. The authors, Pierce and Lipcon, reported a family history of enuresis in 69.5 per cent of the enuretic group, and in 9.5 per cent of the controls. A family history of somnambulism was reported in 25.5 per cent of the enuretics, and in 10.5 per cent of the controls. A family history of epilepsy was established in eight per cent of the enuretics, and in two per cent of the controls. Personal history of somnambulism was admitted by 34 per cent of the enuretic group, and 10.5 per cent of the controls. A history of epilepsy was proved in three per cent of the enuretics; none was found in the controls. In general, the recruits in the enuretic group were described as passive, infantile, and sensitive. The authors suggested that epilepsy, enuresis, and somnambulism may all be symptoms of a similar physical disorder. The disturbances may be genetically determined and may result from pathophysiological changes that occur during sleep and that are influenced by emotional stress. According to Pierce and Lipcon, additional knowledge might be gained from further investigation of the metabolism of sleep.



Electroencephalograms during sleep show a difference in patterns of enuretic adults and children. Fig. 1 is the tracing of an adult who voided when the pattern showed a waking state. Micturition occurs in children during deep sleep.

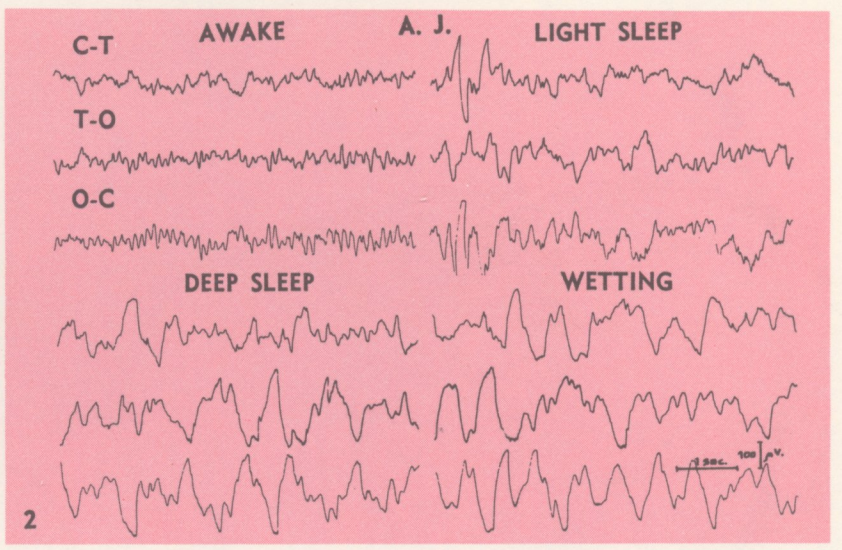


Fig. 2 is the tracing of a child. Ditman, K. S., and Blinn, K. A.: Sleep Levels in Enuresis, Am. J. Psychiat. *111*:913 (June) 1955, published by The American Psychiatric Association. *Reproduced by permission of authors and publisher.*

Ditman and Blinn have reported a study of sleep levels in enuresis. The subjects were 25 males whose ages varied from five years to 20. Twenty-two of these were naval recruits, aged 17 or older. All the subjects were physically, psychiatrically, and urologically normal, except one adult who had a moderate urethral stricture and somnambulism. None of the subjects had a family history of epilepsy. The adults were described as being of the immature, anxious, passive-aggressive personality types.

The sleep of each subject was monitored by continual nocturnal encephalographic record. The subjects reached a state of light sleep within 15 minutes, and deep sleep within 55 minutes. Upon awakening, none of the subjects was aware of having voided. In most of the adult cases, however, the electroencephalographic tracing showed waves compatible with the physiological waking state immediately before and during micturition. There was also evidence that a psychic struggle occurred at these times. The only adult who voided in deep sleep was the one with urethral stricture. The conclusions made from this study include the belief that enuresis is not a form of epilepsy nor is it related, except that incontinence may be part of the pattern of a seizure. Enuresis in deep sleep occurs in early childhood, but in the adult does not result from excessively sound sleep. The subject may resist arousal (contact with reality) but he is physiologically awake.

In the authors' opinion adult functional enuresis is a psychopathological problem, and psychotherapy is recommended as treatment. An additional suggestion was made that the electroencephalograph be used as a diagnostic aid in cases of adult enuresis of undetermined origin.

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Diagnostic and Statistical Manual Mental Disorders, Washington, D. C., American Psychiatric Association Mental Hospital Services, 1952, p. 32.

Ditman, K. S., and Blinn, K. A.: Sleep Levels in Enuresis, Am. J. Psychiat. **111**:913 (June) 1955.

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Company, 1945, p. 232.

Pierce, C. M., and Lipcon, H. H.: Clinical Relationships of Enuresis to Sleepwalking and Epilepsy, Arch. Neurol. & Psychiat. **76**:310 (Sept.) 1956.

THE DISCHARGED PATIENT

Continued from page 36

therefore offers a protection similar to that in the hospital environment. He can provide opportunities for the patient to discuss particular transitional difficulties, and encourage him in the efforts he makes at self-adjustment. Aldrich pointed out, however, that the physician must guard against judging the patient's attempts by his own standards. For example, a schizophrenic patient who is urged to participate in group social activities may force himself to do so only to suffer a recurrence of illness. Preferably the patient should be allowed to set his own social limitations. He may choose fewer outlets than are conventional but he will also be more likely to remain out of the hospital.

Frequently, the success of rehabilitation depends upon maintenance of drug therapy. Relapse, in a large percentage of cases, is the direct result of discontinuation of drugs. Both the patient and the family may need to be reminded of this factor.

Perhaps with the combined efforts of national, state, and county organizations, and the active participation of general practitioners, the patients discharged from mental hospitals will be afforded the continued care that they need. According to Goshen, a third of the present mental hospital population could be released if adequate follow-up care were available.

Suggested Reading

Aldrich, C. K.: Psychiatry for the Family Physician, New York, McGraw-Hill Book Co., Inc., 1955, p. 177.

Booher, N. R.: A Mental Health Program for a State Chapter, GP **26**:147 (Sept.) 1957.

Gorman, M.: The General Practitioner: Powerful Ally Against Mental Illness, GP **26**:142 (Sept.) 1957.

Goshen, C. E.: Follow-up Programs for Discharged Mental Hospital Patients, Employing the Services of the Family Physician, The General Practitioner Education Project of the American Psychiatric Association, a report released for publication.

PERCEPTION AND DECISION IN ANXIETY: In order to test the effect of anxiety upon perceptual function, 19 patients with free anxiety, or a tendency to develop anxiety under stress, volunteered to participate in The Area Judgment Test. None of the patients was overtly psychotic. The control group consisted of 18 nonmedical employees, selected on the basis of comparable age, sex, and educational level. The test material included 45 cards, each with two squares of different size, color, and position. As the cards were shown, each examinee was asked to determine whether one square was larger; his reply was judged for accuracy and time. The patients were given one pre-experimental test, and then were tested before and after a stress interview on three successive days. On the first day, the patients who were most disturbed by the stress interview were more accurate and slower in judgment; on the second day, increased anxiety resulted in less accuracy and more rapid response; on the third day, both accuracy and speed decreased. The authors stated that moderate anxiety seems to facilitate performance, whereas intensified anxiety disrupts it. Accuracy was found to be more closely related to anxiety than was length of time in the patient group. The greatest difference between the subjects and the controls, however, was in the longer time required for the patients to decide.

Korchin, S. J., et al.: Visual Discrimination and the Decision Process, Arch. Neurol. & Psychiat. **78**:425 (Oct.) 1957.

FEAR OF SHOCK THERAPY: Several theories have been suggested to explain patients' manifest fears of electric shock treatment. Whether the reactions are universal, idiosyncratic, or chance phenomena is unknown. Investigation of an individual's particular method of defense against this experience may provide insight into the dynamics of his disorder, or, conversely, prediction of the reaction may be possible with knowledge of the mechanisms of his illness. Individual reaction is evident from a diary kept by a schizophrenic patient. This patient repeatedly expressed specific fears of punishment, helplessness, humiliation, and damage to his mind. Other patients have expressed the same ideas, but not in the same number or content. Reference to fear of humiliation has been brief in the literature on this subject. The author contends that emotional reaction to electric shock therapy is not a chance occurrence; it is, instead, a dynamically determined manifestation and can be comprehended only by understanding of the individual patient's unconscious mechanisms.

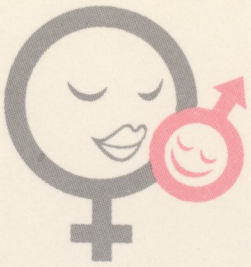
Friedman, M. H.: Fear of Electroconvulsive Therapy, Arch. Neurol. & Psychiat. **78**:385 (Oct.) 1957.

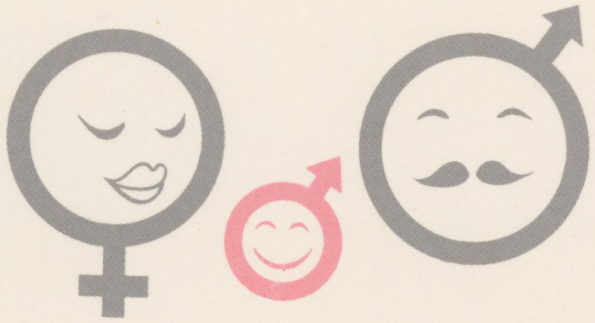
PSYCHOGENIC DYSPNEA: Psychoneurosis was established as the basis for unexplained dyspnea in a study of five patients. Four of the patients had anxiety neurosis, and the fifth suffered from neurotic depression. In all of the cases, hyperventilation was inversely related to the severity of dyspnea. Two patients who were greatly distressed by difficulty in breathing did not evidence any signs of hyperventilation. The other three were unaware of their labored breathing, although associates had noticed it. These three had hyperventilation symptoms which included mild tingling sensations in the hands and feet in one patient; vertigo and a feeling of ascending numbness in the extremities in another; and, in the third patient, cyanosis and tetany. All had had some previous organic disorder that affected respiratory function before development of psychogenic dyspnea. The author suggested that respiration may have thus become a significant area of neurotic expression. All five patients responded favorably to psychotherapy.

Kissin, B.: Psychogenic "Dyspnea" and the Hyperventilation Syndrome, Am. Pract. & Digest Treat. **8**:1537 (Oct.) 1957.

PREPARATION FOR AMPUTATION: Prevention of acute anxiety and postoperative pain after amputation is aided by discussion of four significant points with the patient, whether child or adult. First, the decision to perform the procedure is supported, with emphasis upon the necessity. The patient is encouraged to express his anger. Second, the associated sadness and regret at the loss of the limb are discussed, and opportunity provided for expression of emotional distress. Third, the phantom limb phenomenon is described, with explanation of the kind of sensations that might be experienced. Fourth, the patient, particularly the adult, is helped to verbalize concern about disposition of the limb. Patients are usually hesitant to ask about this aspect of the procedure, but it is of great importance to many prospective amputees. The authors report minimal anxiety and almost no phantom limb pain after such preparation. They recommend that the method be incorporated into the medical regimen for patients who must undergo amputation.

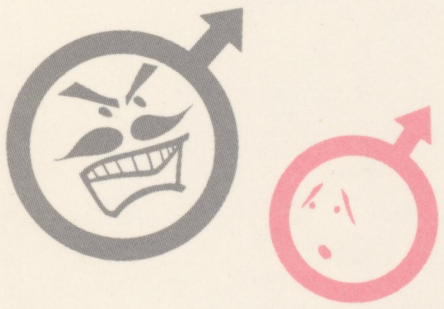
Johnson, A. M., and Griffin, M. E.: The Disturbed Child, Postgrad. Med. **22**:220 (Sept.) 1957.



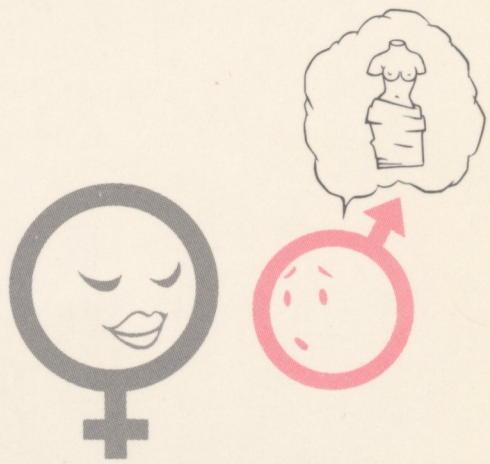


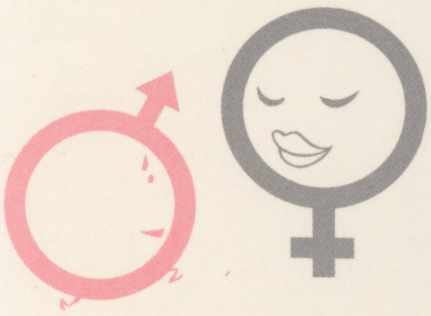
THE OEDIPUS COMPLEX

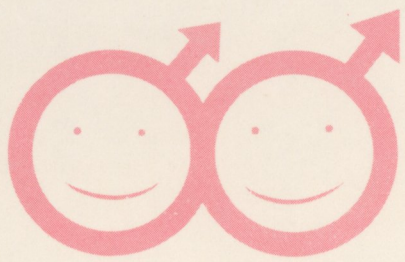
Abnormal Resolution in the Male



Normal resolution of the Oedipal situation results in adult heterosexual orientation, whereas abnormal resolution may result in homosexual orientation. At first, the infant's state is that of primary narcissism, in which he merely reacts to stimuli, and enjoys comfort and satiety without awareness of source. Differentiation of objects begins with recognition of the mother and soon extends to the father. Thereafter, however, inversion may result from one of two processes. If the father appears forbidding, or ineffectual, the child may identify with the mother, and develop feminine characteristics which seem to him more worthy of emulation. In this instance, the individual becomes an effeminate adult who offers his male object choice the attention he himself received from his mother. Conversely, the mother may appear unattractive to the extent that the child rejects her, and, subsequently, avoids association with women. This adult's object choice, then, must fulfill the requisite of masculine physical characteristics. Both processes, whether feminine identification or rejection, may result in homosexual orientation.







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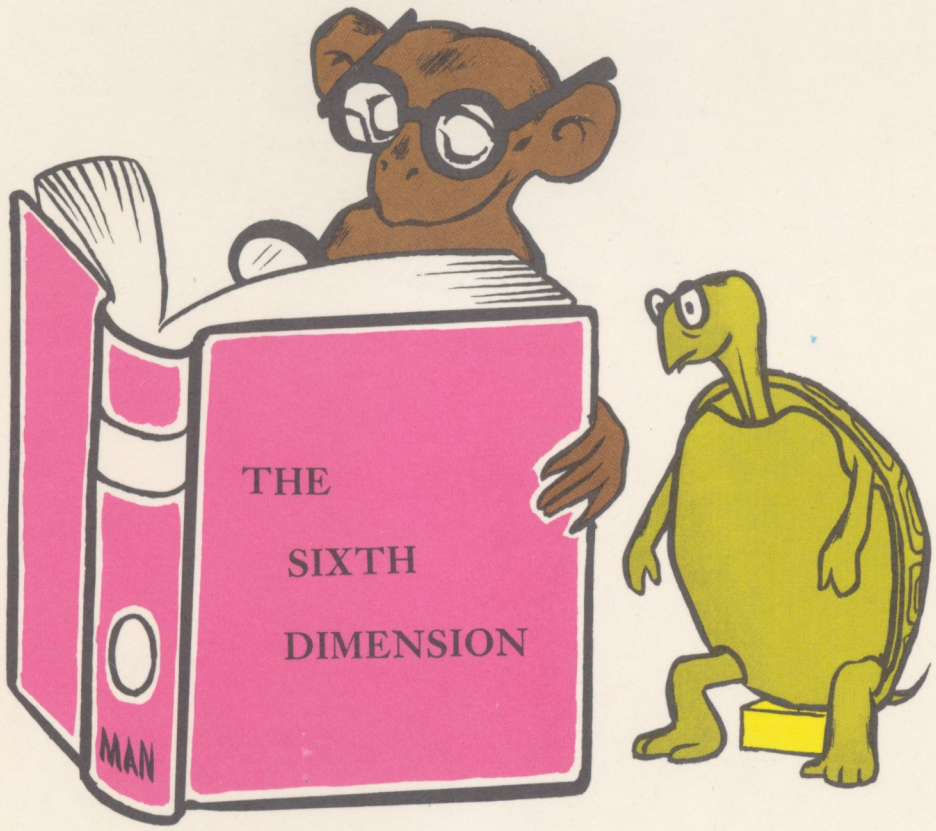

"The lively force of his mind has broken down all barriers, and has made its way far beyond the glittering walls of the Universe."

Lucretius.